



**Patient and Family Advisory Council (PFAC)  
Application**

**Please tell us about you or your families experience at Independence Health System.**

1. Have you or a close friend or family member been a recipient of ANY healthcare services in the last three years?  Yes  No
  - a. If yes, where? (select)  in a hospital  outpatient (doctor's office, diagnostic testing, etc.)  other (list) \_\_\_\_\_
2. Have you ever been the caregiver for a patient who was hospitalized in the last three years at an Independence Health Hospital?  Yes  No
3. How would you describe your experience?

4. What did the hospital do well during your stay or your loved one's stay?

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5. What could the hospital have done better during your stay or your loved one's stay?

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6. What would you like the hospital to learn from your stay or your loved one's stay?

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*If you have more to say, please feel free to use additional pages.*



**Please tell us more about you.**

1. Please tell us your name and the best ways to reach you?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Best time of day to contact you: \_\_\_\_\_

2. Do you volunteer in your community? If so, for which organizations? (example: churches, schools or volunteer groups)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Do you feel comfortable working in groups, speaking up and providing input?

\_\_\_\_\_  
\_\_\_\_\_

4. Is English the language you primarily use when communicating?

Yes  No

If your answer is no, what is your primary language? \_\_\_\_\_

5. Are you able to attend monthly meetings at 730 am?  Yes  No

6. Are you willing to sign an agreement promising not to disclose confidential information given to you in your role as a member of the Patient and Family Advisory Council?

Yes  No

*This application can be mailed to: Patient Advocate, Independence Health System, 1 Hospital Way, Butler, PA 16001 or return a completed copy to [Rebecca.clouse@independence.health](mailto:Rebecca.clouse@independence.health).*

**Thank you!**